Executive Summary
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Implementing Organizational Design Options for State Cancer Planning: Developing Model Comprehensive State Plans

to

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Table of Contents

List of Tables and Figures

Executive Summary

This final synthesis report presents findings for the project "Implementing Organizational Design Options for State Cancer Planning: Developing Model Comprehensive State Plans." The purpose of the project was to (1) determine the essential elements for planning, (2) provide technical assistance and evaluation support during the planning process, and (3) provide guidance to future comprehensive cancer control planning efforts. This report focuses on the first two purposes. A companion document, the *Guidance Document and Toolkit*[1], addresses, fulfills the third purpose of the project. The *Guidance Document* is being disseminated widely among states, tribal organizations, territories, agencies, and other organizations.

The report begins with a history of the concept of comprehensive cancer control. It traces the development of the concept through two predecessor projects that generated much information on the strengths and challenges of the comprehensive approach to prevention planning. The report then presents information on the practical application of comprehensive cancer control in six states—Arkansas, Illinois, Kansas, Kentucky, Maine, and Utah—known as model planning states. The application of comprehensive cancer control and further development of the concept occurred during the current project, which became known as "the model planning project." The report discusses technical assistance (TA) that was given to states (including peer mentoring among states) and also summarizes the descriptive evaluation findings for the project. It ends with a brief overview of the guidance that was developed in the companion document and a series of recommendations for future comprehensive cancer control initiatives based on project findings.

Development of the Comprehensive Cancer Control Concept

Beginning in 1995, the Centers for Disease Control and Prevention (CDC), Division of Cancer Prevention and Control (DCPC), undertook several tasks to better understand the concept of comprehensive cancer control and what putting it into practice might entail. These include development and implementation of a definition and identification of challenges (consensus-building activities); a baseline assessment of comprehensive existing cancer control programs, activities (information-gathering activities); and case studies of cancer control programs in states (knowledge-generation activities).

Consensus-building activities. As defined by CDC, comprehensive cancer control is *"an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation."* CDC worked with stakeholders from a wide variety of federal, state, and voluntary agencies to establish this definition and identify challenges that may surface once it is applied. Challenges identified included (1) organizational disruptions in state health agencies; (2) changes in the role of state government leading to increased decentralization of programs; (3) varying levels of readiness and resources among the states, tribes, and territories that would develop and implement plans; and (4) categorical funding streams.

[1] Battelle. *Guidance Document for Comprehensive Cancer Control Planning with Toolkit*. Prepared in collaboration with the Centers for Disease Control and Prevention, Division of Cancer Prevention and Control. Revised Final Draft. March 2001.

Information-gathering activities. CDC worked with Strategic Health Concepts, Inc. and Battelle to conduct a baseline assessment of cancer control activities and other efforts considered to be comprehensive as of 1997. These activities included reviewing state cancer plans and the related literature. One result of the literature review was publication in 2000 of a Framework for Comprehensive Cancer Control.[2] The framework presented comprehensive planning as a cyclical process comprising four phases: (1) setting objectives based on data, (2) using existing research to determine a range of strategies for meeting objectives, (3) planning feasible strategies, and (4) implementing strategies that are effective and yield desired outcomes.

Knowledge-generation activities. In late 1997, CDC contracted with Battelle to make site visits and conduct case studies in six states. Two of these states, Michigan and North Carolina, were experienced with comprehensive cancer control. Four of the states—Arkansas, Illinois, Maine, and Utah—were considering the development of comprehensive cancer control plans. A major purpose of the site visits was to discern the "essential elements" for comprehensive cancer control. After synthesizing the information from all six cases, researchers recommended that the following programmatic elements be considered essential[3]:

- Strong leadership from the state health agency with commitment of one or more staff persons.
- Effective public-private partnerships that bring expertise and resources to comprehensive cancer control planning and implementation.
- Access to valid planning data and sound scientific expertise that supports effective planning and evaluation.
- Funding that supports both planning and implementation of comprehensive cancer control programs.

Application of the Comprehensive Cancer Control Concept-The Model Planning Project

As noted above, the model planning project served as the practical application of the comprehensive cancer control concept, testing the framework and essential elements and developing new models and tools that incorporated the earlier contract work. Several forms of technical assistance (TA) were offered to states as part of the model planning project:

- **Guidance Document**.[4] Drafted in early 1999, the document outlined a series of activities for each of the three planning stages. These stages are (1) laying the groundwork, (2) developing the comprehensive cancer control plan, and (3) completing the comprehensive cancer control plan.

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[2] Abed J, Reilley B, Butler MO, Kean T, Wong F, Hohman K. Developing a framework for comprehensive cancer prevention and control in the United States: an initiative of the Centers for Disease Control and Prevention. J Public Health Manag Pract 2000 Mar;6(2):67-78. Also available at http://www.cdc.gov/cancer/ncccp/tools.htm.

[3] Butler, MO, et al. *Essential Elements for Developing/Expanding Cancer Control Programs: Design Options for State Health Agencies.* Report prepared by Battelle for CDC. December 1998.

[4] Battelle. Draft *Guidance Document for Comprehensive Cancer Control Planning.* Prepared in collaboration with the Centers for Disease Control and Prevention, Division of Cancer Prevention and Control. March 1999.

- **State-specific TA**. Each of the model planning states worked with a CDC program consultant and a Battelle TA liaison, forming a team that dealt with requests for specific information (e.g., assessing the economic burden of cancer in a state) or specific assistance (e.g., meeting facilitation). These were usually discussed during monthly conference calls.

- **Peer mentoring**. Another particularly successful route for addressing TA requests was peer mentoring. Early in the project, recipients of CDC implementation grants[5] often provided this type of assistance to model planning states. Recipients of implementation grants were states or tribal organizations that had completed a comprehensive cancer control plan and were receiving competitive funding from CDC to implement components of their plans. In particular, Michigan and North Carolina offered a great deal of assistance to model planning states in such areas as partnership building, data issues, and overall plan development. As the project progressed, model planning states more actively mentored each other.

- **All-state conference calls**. Through a series of conference calls, all model planning states were able to meet together to receive information pertaining to one or more timely topics for the comprehensive cancer control initiative in the states. A July 1999 conference call on evaluation was a turning point in the project. During this call, participants answered a series of questions in designed to elicit a description of their state's comprehensive cancer control initiative and to stimulate thinking about the vision, objectives, and desired outcomes of the process.

- **Workshops and meetings**. Model planning state representatives attended three face-to-face meetings that provided opportunities for networking as well as for gathering new information. In December 1998, the model planning states participated with other states interested in comprehensive cancer control in an orientation meeting and workshop entitled "A Comprehensive Approach to State-Level Cancer Prevention and Control Planning-Challenges and Lessons Learned." In September 1999, both model planning states and implementation grantees participated in a preconference session at CDC's biannual cancer conference designed to give participants tools for evaluating their comprehensive cancer control initiatives. The product of this meeting was the first iteration of the Conceptual Model of Comprehensive Cancer Control (see figure ES-1). In October 2000, implementation grantees again joined model planning states for a reverse site visit and evaluation workshop. The reverse site visit afforded CDC and Battelle an opportunity to present preliminary findings from evaluation site visits recently completed in each of the model planning states, and for model planning states to present some of their accomplishments to each other.

Evaluation Approach and Findings

The evaluation approach took advantage of stakeholder knowledge about comprehensive cancer control planning. First, part of its TA function, Battelle determined the nature of evaluation challenges in the model planning states. Second, practitioners from some of the model planning states and implementation grantees worked with CDC and Battelle to develop a model that included problem statements, objectives, activities and outcomes for comprehensive cancer control. Finally, Battelle tested the accuracy of the model through an analysis of data collected from states. This approach was not linear in nature, but was refined throughout the course of the project. For example, as Battelle worked more closely with states the

[5] The implementation grantees were Colorado, Massachusetts, Michigan, North Carolina, Northwest Portland Area Tribal Board and Texas.

model was refined, and the refined model served as a template for evaluation findings. These findings were shared with states and led to new insights into TA needs.

Evaluation Activities

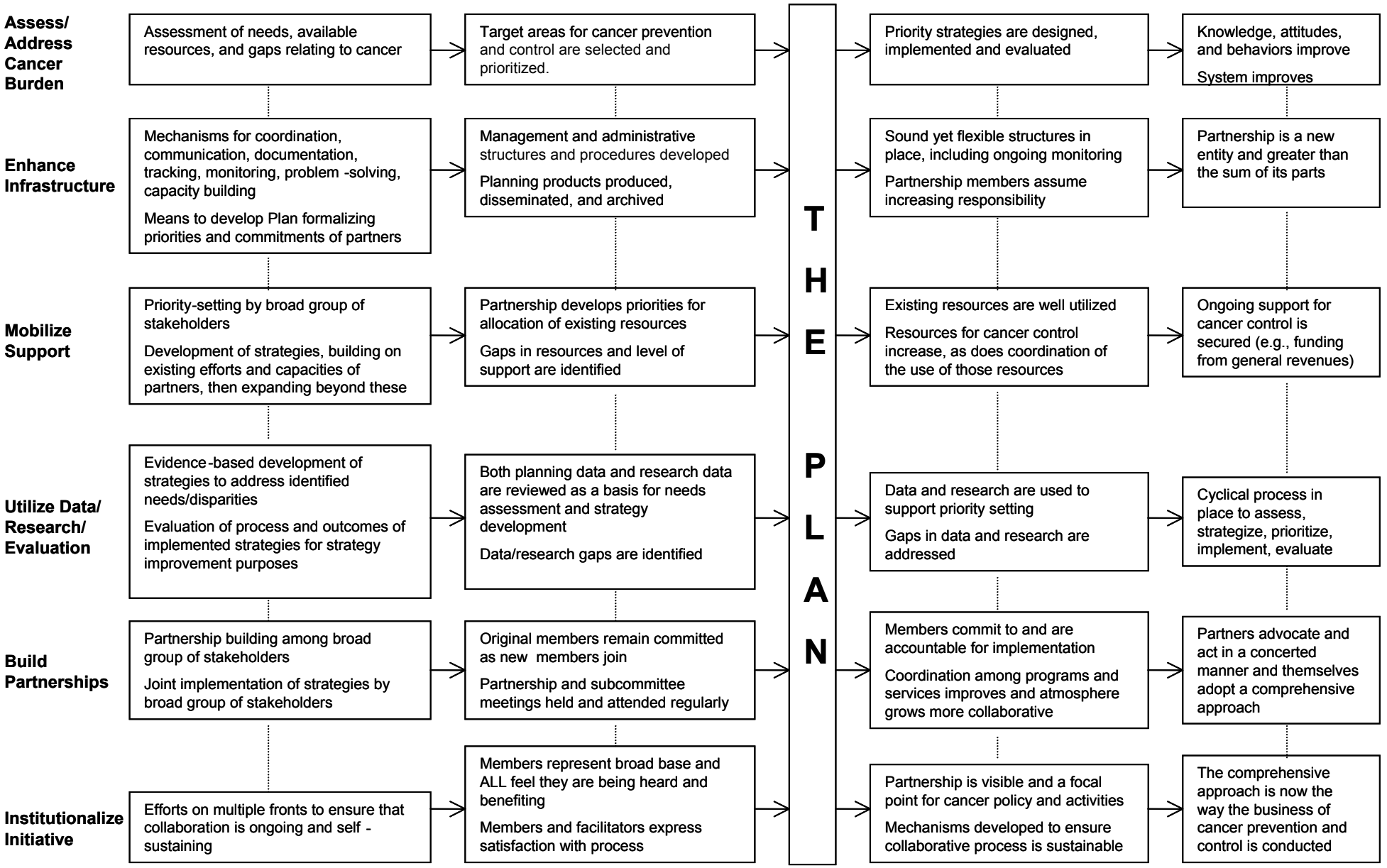
The evaluation consisted of three major activities, (1) development of the Conceptual Model of Comprehensive Cancer Control, (2) evaluation site visits, and (3) completion of a State Activities Tool. This approach allowed for a detailed descriptive evaluation of planning, and the formulation of guidance for future process and outcome studies, as presented in the 2001 *Guidance Document with Toolkit.*

Conceptual Model of Comprehensive Cancer Control. The conceptual model was developed in collaboration with comprehensive cancer control practitioners in the six model planning states and the six implementation grantees. As shown in Figure 1, it consists of six rows or conceptual areas. Each row contains a set of activities for meeting the objective for the conceptual area, planning outcomes, implementation outcomes, and program outcomes. The full statement of each objective and the problem statement that the objective is designed to meet is presented in Table 1.

Table 1. Cancer Control Problems Addressed by the Conceptual Model of Comprehensive Cancer Control

Problem Statement	Objective
Assess/Address Cancer Burden. Unacceptable and persistently high cancer morbidity and mortality rates; continuing disparities in knowledge, access, treatment, and survival among subpopulations.	Reduce morbidity and mortality from cancer overall and reduce disparities in cancer burden among subpopulations.
Enhance Infrastructure. Existing infrastructure for cancer prevention and control is inadequate in most states, territories, and tribes.	Develop and/or enhance the management and administration necessary to support comprehensive cancer prevention and control.
Mobilize Support. Too few resources for cancer prevention and control in states, territories, and tribes (including staff and funding); fierce competition for available resources; lack of flexibility among categorical funding streams; minimal support for cancer programming from state and local governments.	Improve use of existing resources and increase the level of support available overall.
Utilize Data/Research/Evaluation. Planning decisions made on an *ad hoc* basis with little consideration of evidence; lack of integration of data staff in program planning; implemented programs not regularly evaluated; inadequate and poorly linked surveillance and other data systems; underreporting of some cancers and nonreporting of treatment data; misclassification of individuals in data that are collected; minimal support for data analysis.	Increase the extent to which decisions are made on the basis of sound evidence (including evaluation feedback).
Build Partnerships. Lack of focus, integration, and coordination among cancer programs and services and those who provide them; low-priority status of cancer among competing agendas; conflicting practice guidelines; fragmented and inequitable health care systems.	Increase awareness and involvement of broad sectors of the citizenry in cancer programming and improve coordination and collaboration among stakeholders.
Institutionalize Initiative. One cycle of planning and implementation is insufficient to accomplish all that needs to be done in the area of cancer prevention and control.	Build in sustainability of the comprehensive cancer control initiative from the outset and work toward institutionalization.

Figure ES-1 Conceptual Model of Comprehensive Cancer Control



Evaluation site visits. Between May and October 2000, two Battelle staff members and one CDC program consultant conducted a series of meetings and interviews in each state. State-based participants included the coordinator for planning, the chronic disease director, core team members, expanded team or internal work group members, and active partners. Interviews were conducted in a discussion format, usually in small groups. Each site visit included time to review the State Activities Tool and discuss any remaining TA concerns with planning staff. The findings from the site visits were analyzed according to the conceptual model and are discussed below.

State Activities Tool. In mid-2000, as part of project evaluation, CDC and Battelle worked with each state to complete a State Activities Tool. The tool was developed from a table of recommended activities in the March 1999 draft *Guidance Document*.[6] One result of the exercise was that it allowed for an assessment of how realistic the original *Guidance Document* had been. This exercise confirmed verbal feedback from some planners that, while helpful, the draft *Guidance Document* was overly prescriptive in the number and types of activities it suggested. The revision of the 2001 *Guidance Document* is discussed after presentation of the evaluation findings

Evaluation Findings

The evaluation findings are presented as they relate to the outcomes (*in italics)* recommended by participants during the development of the Conceptual Model of Comprehensive Cancer Control.

Assess/address Cancer Burden. All states were able to achieve the planning outcome of *selecting target areas for cancer prevention and control*, and most were in the process of prioritizing the target areas by the end of the study period (January 2001). This generally occurred through work groups that developed objectives and strategies. Kentucky achieved this outcome through the work of its core team, with input from selected stakeholders, and by reviewing categorical plans and *Healthy People* goals and objectives for the state. Kentucky completed a draft plan in September 2000. The other two states that completed their plans during the study period, Illinois and Maine, used work groups. Illinois reconfigured its work groups for the implementation of priority strategies. These three states also were able to progress towards achieving the implementation outcome of *designing, implementing, and evaluating priority strategies*, particularly with regard to design.

Enhance Infrastructure. A major finding was that without attention to developing infrastructure at the coordinating agency, a comprehensive cancer control program could not be successfully initiated. Eventually, the first planning outcome, *development of management and administrative structures and procedures*, occurred in all six states through the efforts of planning coordinators who were supported by core teams of coordinating agency staff and expanded teams of staff and key partners. Each state was able to develop systems for *producing, disseminating, and archiving planning products* such as meeting minutes, logs of activities, and drafts of goals, objectives, and strategies. Illinois worked toward the implementation outcome of having *sound yet flexible structures in place (including a mechanism to support ongoing monitoring)* by reconfiguring work groups. Maine expanded its coordinating committee originally composed of state staff members and leaders, to initiate the implementation of its newly completed plan. Maine also expressed its intention to institutionalize the comprehensive cancer initiative. The state incorporated a plan for program institutionalization into the overall state comprehensive cancer control plan and developed an *ad hoc* committee to deal with this issue.

[6] Battelle. *Op cit.* Pages 6-9

Mobilize Support. Support includes not only financial resources, but political will and community buy-in as well. Initially, it requires that the planning *partnership develop priorities for allocation of existing resources.* Three states (Kansas, Maine, Illinois) had iterative processes for prioritizing objectives or strategies based on the presence of resources or sponsors to implement them, and other states were preparing to do the same. As part of the planning process, all states *identified gaps in resources and level of support*. Most were able to develop ways of addressing those gaps, although the outcome of many of these efforts was not clear at the end of the study period.

Most states made modest progress toward achieving implementation and program outcomes for mobilizing support, particularly investigating ways of obtaining *ongoing support for cancer control*. Some states have been looking at varied sources of funding (grants, legislation), but the results of these efforts will not be known for some time. In Illinois, a bill was introduced to allocate $500,000 for comprehensive cancer control activities. Although the bill did not make it out of committee, this was still considered an important first step toward legislative recognition and perhaps financial support. Maine and Arkansas benefited from CDC's Public Health Prevention Specialist Program, with Maine's assignee continuing for a second year and Arkansas's planning facilitator being named as a CDC assignee in 2001.

Utilize Data/Research/Evaluation. All states found ways of meeting the planning outcome of *reviewing both planning data and research data as a basis for needs assessment and strategy development.* However, the ease with which this was accomplished varied depending on the adequacy and accessibility of the data resources in a particular state. In states with well-developed data resources, it was simply a matter of cooperating with data staff to access those data. In states where data resources were less well developed, the comprehensive cancer control process itself focused attention on the state's data resources and led to actions to promote development and improvement of data.

Kinds of evidence used to support the comprehensive cancer control planning process were (1) incidence and mortality data, (2) Behavioral Risk Factor Surveillance System (BRFSS) data, (3) other kinds of data from state agencies (e.g., hospital discharge data, Medicaid/Medicare data,) (4) data from partner organizations, and (5) research literature on effective interventions. Staff members who helped incorporate data into the planning process included state epidemiologists, cancer registry personnel, and others in charge of state data sources. Kansas developed a unique way of using data experts by making designated "backgrounders" (data experts in a particular topic area) available to work groups.

A second expected planning outcome was the *identification of research gaps.* This occurred in all six model planning states; for example, improvements in skin cancer reporting were called for in two states. Arkansas, Kansas and Illinois showed evidence of *addressing these gaps* (an implementation outcome in the conceptual model). Illinois and Maine also showed evidence of putting systems in place that could lead to meeting the program institutionalization outcome, *establishment of a cyclical process to assess, strategize, prioritize, implement, and evaluate* needed data and information.

Build Partnerships. The first expected outcome for partnership building was that *original members would remain committed as new members joined* the partnership. Partnership-building activities in the model planning states have included (1) identifying potential partners, (2) assessing interest and commitment of stakeholders, and (3) establishing structure, vision, and broad goals for the partnership. Model planning states work to include new members while maintaining a solid group of original partners committed to both planning and implementation. The model planning states tended to have open membership structures that did not limit membership, even though accommodating new members and bringing them "up to speed" creates considerable work for the planning coordinator. Kentucky did not have an active planning partnership but sought stakeholder input for plan development and partner support for implementation. Arkansas was in the process of looking at ways to integrate 90 new members

who participated in the statewide Cancer Summit and expressed an interest in planning and implementation of the comprehensive cancer task force.

Most states elected to conduct planning through work groups or subcommittees. It was expected that *meetings of both the partnership as a whole and of the subcommittees or work groups would be held and attended regularly.* This was true for all four of the states where work groups were established. (Arkansas was in the process of developing its work groups at the end of the study period. Kentucky did not elect to have work groups for planning.)

Work group members showed progress toward achieving the implementation outcome by starting to *signify that they were committed to and willing to be accountable for implementation.* In Maine, partner organizations had to sign up to sponsor an objective or goal for it to be included in the plan. In Illinois, sponsorship of strategies occurred after completion of its action plan through the action reports developed by partners. Even though Arkansas did not call a partnership (task force) meeting until August 2000, once the partners met, they were asked to signal their commitment to implementation at the very first meeting.

Each of the six states showed evidence that *coordination among programs and services was improving and that the atmosphere was growing more collaborative.* This tended to happen through the interaction of the partners although there was also evidence of support for comprehensive cancer planning by stakeholders in categorical issues (e.g., breast cancer advocates in Kentucky).

Institutionalize Initiative. In developing the conceptual model for comprehensive cancer control, planners thought that the quality of the partnership would be a key factor for institutionalizing the initiative. Commitment, based on a *broad member base,* would eventually lead to *a visible partnership that is a focal point for cancer policy and activities* in the state, territory, tribes, or other organization. It is premature to judge whether this belief is indeed accurate, but is apparent that states are conducting activities that may lead to such an outcome. For example, to ensure a representative and inclusive partnership some states, such as Utah, took deliberate steps to assess gaps in their partnerships and recruit new members. Model planning states also developed ways of ensuring *member satisfaction with the process.* This included paying attention to the quality of both the partnership and work group meetings and maintaining contact with members between meetings. Maine formally considered program institutionalization early in its process and designed a structure for ensuring an ongoing comprehensive cancer control initiative that was presented to partners as part of the state's plan.

Translation of Findings into Guidance for Comprehensive Cancer Control

Early in the model planning project, it was thought that specific organizational design options could be developed for particular types of planning environments (e.g., highly centralized with leadership in state health agency, diffuse planning partnership but with leadership in state health agency, leadership outside the state health agency). The evaluation findings proved more complex than this scenario would suggest. However, through synthesis of the evaluation findings and careful analysis of the State Activities Tools, it became apparent that the Conceptual Model of Comprehensive Cancer Control provided a good representation of the comprehensive cancer control process. However, it had to be operationalized to provide specific guidance to states and other organizations that are engaged in comprehensive cancer control planning.

The analysis of the State Activities Tools confirmed that there are three broad stages of comprehensive cancer control planning, as presented in the 1999 draft version of the *Guidance Document*. However, planners determined that the activities suggested at that time should be streamlined and arrayed in a

format similar to the conceptual model but focused solely on planning. The Building Blocks of Comprehensive Cancer Control was developed and formed the basis for the 2001 *Guidance Document.* The building blocks are (1) enhance infrastructure, (2) assess/address cancer burden, (3) mobilize support, (4) utilize data and research, (5) build partnerships, and (6) conduct evaluation. This arrangement

- Demonstrates that the implicit "themes" in the framework model and the "essential elements" identified in the case studies are actually building blocks that are necessary if a state, territory, or tribe is to assess and address its cancer burden in a comprehensive manner.

- "Zooms in" on the Activities column of the conceptual model, providing further detail on specific activities that can be undertaken during comprehensive cancer control planning in relation to each building block. By contrast, the conceptual model is outcomes-oriented.

- Separates the conceptual area for Data, Research, and Evaluation into two distinct building blocks (Utilize Data/Research and Conduct Evaluation). Planners recognized the need for this distinction through an analysis of both the State Activities Tools and the technical assistance needs of the model planning states. It was found that staff members and their partners need assistance with integrating evaluation into planning activities. Otherwise, evaluation receives very little attention until the plan is implemented, and this may result in a loss of important process information and the development of some of the plan strategies are in a way that does not allow them to be evaluated easily.

- Ends with a list of expected planning outcomes by building block and with achievement of the planning goal, namely, production and dissemination of the comprehensive cancer control plan.

Recommendations

Findings from the evaluation site visits and analysis of State Activities Tools, as well as reflection upon the experience of providing TA (as documented in minutes of monthly conference calls and all-states conference calls) led to the development of recommendations for future comprehensive cancer control planning efforts. Table 2 presents these recommendations. The topics for the table are derived from the conceptual areas in the Conceptual Model of Comprehensive Cancer Control (Figure 1). In addition, a seventh topic, Conduct Evaluation, is included. This is because a major finding of the project was that states need specific guidance during the planning stage.

Table 2. Recommendations for Comprehensive Cancer Control Planning

Topic	Recommendations
Assess/Address Cancer Burden	*Develop a structure for partner input.* The major structure for including partners in the work of assessing and addressing cancer burden was through work groups or subcommittees that were developed around the issues or categories to be addressed by the comprehensive cancer control plan. *Work groups should reflect categories that are selected by the partnership.* There is no one way of defining the nature of work groups. Some states prefer work groups that are focused on cancer sites or risk factors (e.g., breast cancer, tobacco control), while others favor cross-cutting issues (e.g., access to care). Partners should have buy-in to the structure of the work groups, and the structure may be assessed and modified at critical junctures, such as at the transition from planning to Plan implementation. *Develop a common language.* Often people from different backgrounds define terms like goals, objectives, indicators, outcomes, strategies, and priorities differently. Be sure that everyone is using the same terminology when writing sections of the plan. Train facilitators to use work sheets that are easily reviewed by staff members or a core group of partners.
Enhance Infrastructure	*A dedicated staff is needed for progress to be made*. A comprehensive cancer control effort requires the time and attention of dedicated personnel ideally with a full-time coordinator. However, if this is not possible, part-time staff members can be effective provided they are given a great deal of support from supervisors and peers. *Comprehensive cancer control planning is a team effort.* Including members who are already active in cancer-related issues (e.g., epidemiologists, BCCP coordinators, tobacco program coordinators)-a core team is crucial for assisting the comprehensive cancer control coordinator. *Supplementing the core team before developing a full partnership can be very useful.* An expanded team or internal work group can be seen as a first-level partnership-that is having partners from within the coordinating agency and perhaps from a few key external agencies (e.g., American Cancer Society). The expanded team reviews products of the core team, provides further input into decision-making, and may take on other tasks as well. *The state health department is only one possible home for comprehensive cancer control planning.* Although the previous recommendations encourage the use of staff members from state health agencies in the core team and, to a large degree, the expanded team, the staffing pattern can be translated for the structure of a variety of agencies. Among the model planning states, Kentucky housed its program in a university-affiliated cancer program. Other possibilities exist as well.
Mobilize support	*Make strategic decisions about partners.* Support is needed from a broad sector of the population, including representatives of organizations likely to implement plan strategies, legislators who can provide political support, representatives of target populations, and representatives of organizations that may be able to fund strategies. *"Think outside the box."* When considering funding sources, explore opportunities beyond government agencies. Pharmaceutical companies, health insurance plans, foundations, and businesses that are visible in the community are just some of the entities that may support components of the comprehensive cancer control plan. *Be alert to opportunities for supplementing staff.* Local universities can contribute staffing support or consultation, particularly in program evaluation. Two model planning states received assistance in moving the planning project into the implementation stage by obtaining staff members from CDC's Public Health Prevention Specialist program.

Topic	Recommendations
	Go public. Model planning states used approaches like displaying posters, speaking at state wide events, and applying for CDC conference grant funds to host large-scale comprehensive cancer control conferences.
Utilize Data and Research	*Invite Cancer Registry staff members and other data and surveillance professionals to participate in planning on several levels.* Invite such professionals into the process early. Opportunities for their participation include serving as core team members, expanded team members, partners, work group members, work group facilitators, or expert presenters or reviewers. Consider whether a data and surveillance work group or subcommittee should be formed, or strategically place individuals who are knowledgeable about data in as many of the work groups as possible. *Use the knowledge of clinical and academic experts.* Clinicians and academics, as well as graduate students, can contribute to an understanding of research reports and other relevant scientific literature that is necessary for deciding on objectives and strategies. Those who are too busy to join the partnership may function as "expert consultants." *Work with data experts so that presentations to other partners are "user-friendly."* Presentations to partners should be meaningful to members with scientific backgrounds, but should break down key concepts and avoid jargon for those who are less familiar with the data sources used in comprehensive cancer control planning. *Ensure that key decisions are based on sound data or research reports.* Although comprehensive cancer control planning is an evidence-based process, it may not be feasible to obtain all of the data that are desirable for planning. Therefore, additional data collection or analysis activities may be incorporated into the plan itself.
Build Partnerships	*Lay the groundwork before developing the partnership.* A strong foundation can inspire confidence that the comprehensive cancer control process will accomplish its goals. Therefore, time spent on enhancing infrastructure, working with the core and expanded teams to seek out data sources and resources, and creating a vision is worthwhile. When external partners are brought on board, everyone will then be able to work together in a cohesive manner. *Strategize about whom to include in the partnership*. Including partners with very different backgrounds can be challenging, but it also can be rewarding. The greater the diversity in the partnership, the more inclusive it will be; therefore, the likelihood of incorporating varied viewpoints will increase. However, there is a trade-off in efficiency when the partnership is very broad. *Consider ways of involving people who may not have time to participate in every activity.* For example, medical academics with very busy schedules may serve only as advisors or reviewers of products. Clinicians or service providers who work with patients or community agencies may not be able to leave their place of employment, but can join work groups through conference calls. *Pay attention to maintaining the partnership.* This can include simple strategies such as telephoning partners who miss meetings, or more time-consuming strategies such as working to bring in new individuals and organizations over time. Be especially cognizant of important groups that are not yet represented, or that start to participate but then drop off, and find ways to include them. *Stay focused on the reason for planning.* Comprehensive cancer control is more than the product, but working toward a product-the comprehensive cancer control plan-is a necessary condition for success. Producing interim products (e.g., meeting minutes, work group reports) and a clear time line helps to maintain focus.
Institutionalize Initiative	*Consider the extent to which the partnership will have control over the outcome of planning and communicate this decision to partners.* In general, staff members in model planning states believed that the plan should be the result of a group process, and that they should not dictate what it would look like. Staff members may guide the process but often need to step back and let

Topic	Recommendations
	partners make key decisions on what should be included. For the plan to be a group product and the initiative to be institutionalized, the understanding that decision-making will be ceded to the partnership must be communicated to partners. *Develop leadership within the partnership.* Maine, the state that showed the greatest evidence of program institutionalization, encouraged partners to take on leadership roles in work groups and in the partnership as a whole. Partners and staff members also incorporated a plan for program institutionalization within the state's comprehensive cancer control plan.
Conduct Evaluation	*Develop a vision for planning. A c*omprehensive cancer control plan can become very complex. Therefore, the core team should develop early in the process a road map for planning that lays out a vision of where the state (or other organization) is beginning, its destination, and a limited number of guideposts or benchmarks along the way. Later, partners may revise the road map, and those working on the evaluation plan may add further benchmarks or guideposts to indicate whether the destination is being reached. *Create methods for documenting planning activities.* Simple processes and tools for documenting the ongoing activities associated with planning can be valuable. Examples include maintaining minutes of all meetings, keeping a chronological log of activities, and saving work sheets used by work groups in developing goals and objectives. These items can be reviewed to allow staff to troubleshoot problems, assess gaps in memberships and planning activities, and prepare for implementation and outcome evaluations. *Use local resources.* Tap into evaluation expertise through partners and local universities. Several model planning states and implementation grantees took advantage of the services of graduate students to assist in setting up evaluation and to conduct small-scale assessments of partner participation. Beyond this, consider budgeting for a local evaluation firm or university-based researcher to develop a full-scale evaluation plan, which is critical to demonstrating outcomes once the overall plan is implemented. *Think about evaluation early and broadly.* Formulating a targeted evaluation strategy before the plan is implemented is crucial. This is why early "visioning" exercises are important, as are methods for documenting the planning process. These activities help staff members and partnership leaders know if the process is running smoothly, and if intermediate outcomes (e.g., development of goals and objectives) are being met. Later, as the contents of the plan become clear, specific programmatic and health outcome studies linked to individual strategies can be proposed.